

My Diabetes Action Plan

My Name:	Date:
Doctor or Medical Provider:	ER address:
Doctor's or Medical Provider's Phone:	
When the Doctor's or Medical Provider's Office is Closed :	

Diabetes Nurse Phone Number:

The ABC's of Diabetes Control—ask my doctor or medical provider about:

- ☐ Aspirin once a day to protect my heart and an A1C test every 6 months
- ☐ Blood Pressure Control
- ☐ Cholesterol Control

Know Your Targets	
Blood Pressure: 130/80 or less	Blood Sugar: A1c of less than 7%
What is mine? _____	What is mine? _____
When was it last checked? _____	When was it last checked? _____
Bad Cholesterol: LDL less than 100	Flu Shot: every fall
What is mine? _____	When did I last get a flu shot? _____
When was it last checked? _____	

Talk to my doctor or medical provider TODAY if:

1. I have chest pain or tightness.
2. I feel weak or have tingling on one side of my body.
3. I have new vision or speech problems.
4. I feel burning when I go to the bathroom.
5. I have new sores or redness on my feet.
6. I feel dizzy or confused.
7. I feel thirstier than usual. I need to go to the bathroom more than usual.

Go to ER or call 911 if:



My Medicines	How Much	Reason I am taking
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		



Things I should do:

1. Check my feet every day for sores.
2. Wear proper shoes.
3. Take all my medicines as the doctor or medical provider prescribed.
4. Tell my doctor or medical provider about any problems with my medicines.
5. Wear diabetic identification

Diet and exercise:

